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# P/S/R/O update: March 8, 1976 no. 18

# P/S/R/O Update

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The Medical Cost/Quality Newsletter

Boston University Medical Center


## Early data show hospital stays being reduced where PSRO review is implemented, Congress told

Tentative first data from the fledgling PSRO system indicate hospital stays are being reduced where PSRO review has been implemented, an administration spokesman told Congress Feb. 18.

Initial PSRO reviews show a "favorable impact on hospital practices and the quality of patient care," Robert Van Hoek, M.D., acting administrator of DHEW's Health Services Administration, told a House health subcommittee at a National Health Insurance (NHI) hearing.

### CLASH OVER NHI PLAN

However, the administration clashed at the hearing with the American Medical Association over the potential for PSROs under NHI. Van Hoek argued that the scope of expected services under NHI "heightens the importance of surveillance and control of unnecessary and inappropriate services which are potentially harmful to patients and result in excessive expenditures.... The current PSRO legislation has the basic flexibility to allow it to adjust to any form of national health insurance and to new concepts and methodologies of review." The PSRO system, he said, will constitute a nationwide framework that will be in place by the end of 1978 and available for NHI.

AMA officials advised the subcommittee

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## INSIDE STORIES:



## Interim regs place review of PSRO decisions before SSA's Bureau of Hearings

Hearings and appeals of PSROs' review decisions will be conducted before the Social Security Administration's Bureau of Hearings and Appeals (BHA), according to interim regulations issued by DHEW.

The so-called interim final regulations became effective Feb. 20, upon publication in the Federal Register. The first regulations governing PSRO hearing procedures to be published by DHEW, they apply only to hearings and appeals carried beyond the PSRO or state PSR Council level.

### REPLACE MEDICAID HEARINGS

The new regulations replace Medicaid hearings on challenged PSRO decisions in areas for which the PSRO has specific statutory authority under Section 1155a of the PSRO law--areas that include determining appropriateness, necessity, and quality of care; establishing methods of maintaining profiles; and deciding who shall review.

Not covered by the new procedures is any work done by PSROs under contract--such as deciding Medicaid eligibility, or reviewing for private third parties--or any other activity not specifically mandated in Section 1155a.

Patients, physicians, hospitals and other providers and practitioners all have equal access to the appeals procedure. The single exception is beneficiaries under Title V, which covers Maternal and Child Health. Because PSROs are prohibited from withholding benefits under Title V, even where the care rendered is deemed unnecessary or inappropriate, it is considered unlikely such patients would have cause to appeal.

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## Interim regs place review of PSRO decisions before SSA's Bureau of Hearings

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Where the amount of money involved in a complaint is less than $100, there is no right of appeal beyond the state level. When it is less than $1,000, there is no right to review by a court after the BHA has given its decision.

MD/DO OPINION REQUIRED

The regulations also stipulate that if a complaint involves services rendered by an MD or a DO, the administrative law judge who hears the case must obtain the professional opinion of an impartial MD or DO as part of the evidence.

Interim final regulations differ from proposed regulations in becoming fully effective as of the date of publication. Although DHEW has invited comments until March 22, the regulations must be obeyed as written until they are changed.

In announcing issuance of the regulations, DHEW said it was considered necessary to provide regulations for hearings and appeals for the many conditional PSROs already conducting review; for that reason, it said, notice of rulemaking, public participation and delay in effective date were omitted in issuing interim regulations. ■

## Early data show hospital stays being reduced where PSRO review is implemented, Congress told

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not to put all the NHI quality-control eggs into one basket. "In our view the PSRO record justifying the assumption by PSRO of such a massive task is far from clear," testified Robert T. Kelly, M.D., of the AMA's Council on Medical Service. "We therefore caution against attaching PSRO--lock, stock and barrel--to any national health insurance program....The varied patterns and types of health care in this country can best be fostered in an atmosphere free of rigid uniform controls." Kelly said the AMA does hope PSROs will have a positive impact on improving health care as well as reducing unnecessary care.

KEY IMPACT AREAS

Van Hoek unveiled the following limited data on PSRO impact:

--Information from four newly designated conditional PSROs (South Carolina, Idaho, Hartford County [Conn.] and Greater Oregon) showed an average decrease in length of stay of 22.75 percent. For Medicaid patients, length of stay declined from 7.94 days to 5.68 days, and for Medicare patients from 11.21 to 9.3 days. At a cost of $100 a day, the resulting savings in basic hospitalization cost was $223 per episode of hospitalization for Medicaid patients and $189 for Medicare patients. "It should be emphasized that the more startling rate of change for length of stay among new conditionals--22 percent as compared to 6 percent for the original conditionals--is a function of their state of development," Van Hoek said. "The larger changes in length of stay may be expected when review is first implemented. While we are not certain we can generalize their level of these savings to all 11 million Medicare and Medicaid admissions, we believe PSROs will function in a most cost-effective manner."

--A transfer of Medicare patients with tuberculosis from acute-care hospitals to nursing homes was achieved in the San Joaquin area PSRO. The PSRO assembled representatives of nursing homes, the county health department, hospital discharge planners and local pulmonary-disease specialists who agreed to a change in the community practice of requiring three negative cultures before a TB patient could be transferred to a nursing home. Nursing-home operators had feared loss of licenses and infection of other patients if the time-consuming cultures were not completed. The assembled officials generally agreed that no culture was necessary and only two smears were needed, one at beginning of treatment and one showing decrease in bacteria count after treatment. Therefore, stays for tuberculosis in acute hospitals have been reduced from 22 weeks to two weeks, with some patients going to a nursing home after two weeks and many being sent directly home on medication, Van Hoek said.

--In Western Massachusetts PSRO, a Medical Care Evaluation study was done on the apparent excessive use of antibiotics in patients undergoing vein ligations and stripping for varicose veins at an unidentified hospital. Antibiotics were used for this category of patients in 35 percent of the cases during 1974, peaking at 60 percent during the last quarter of that year. The Professional Activities Study (PAS) norm for hospitals in that area was indicated in 22 percent of the cases as compared with their actual use in 35 percent of the cases. A further analysis showed that such use was justified in two

additional cases and that nine other cases would have qualified were it not for the fact that antibiotics had not been started preoperatively. Had antibiotics not been used in these 11 cases, the hospitals' usage would have fallen below the PAS norm.

Van Hoek said the criteria and standards were realistic, but that a problem existed in "failure to put knowledge into practice." It was recommended that this category of patients be monitored for the appropriateness of antibiotic use and a similar study be conducted of 1975 patient discharges.

PROGRAM GOALS

Van Hoek cautioned that PSROs are not primarily intended to reduce costs so much as to assess the quality and appropriateness of medical care for subsidized patients.

Physician interest in PSROs has shifted so significantly in the past three years that DHEW can't finance new PSROs fast enough to keep up with the growing interest, Van Hoek testified. Approximately 106,480 doctors are now members of organized PSROs, representing nearly one-half of the eligible physicians in those areas.■

## DHEW proposal to use Social Security number as identifier hit by PSROs

Proposed use of Social Security numbers to identify physicians and patients on the uniform hospital discharge abstract, expected to be required by the federal government, continues to rile PSROs, among others.

300 'COMMENTS'

The Bureau of Quality Assurance has received more than 300 responses in the 30-day comment period after the notice of the plan appeared Jan. 16 in the Federal Register. Most comments are negative, and the majority of them focus on the physician identifier.

Because any forum of PSROs provides the opportunity to register objections, one recent meeting gave PSROs of the Mid-Atlantic Conference a chance to tell Assistant Secretary for Health Theodore Cooper, M.D., how they felt about the use of the Social Security number. Cooper responded to the evident satisfaction of those assembled: He agreed with the vigorous objection to the use of Social Security numbers as universal identifiers, saying he thought the use inappropriate for this purpose, and he promised to ask DHEW Secretary David Mathews to consider an alternative method of identification.

At a meeting of New England PSROs for medical care coordinators held in Worcester, Mass., Feb. 12, use of the Social Security number came under attack, with Executive Director Edward J. Lynch of the Rhode Island PSRO calling it part of a fight for turf at the national level over control of data for national health insurance.

Rhode Island, he said, "has made its own decision about who's going to control the data it produces."

A vocal opponent of the proposal has been Morton Chalef, director of the New York Support Center. He calls the proposal "a perversion of the basic concept of the use of the Social Security number," which the law stipulates should be used only for Social-Security and income-tax purposes. Last year he submitted an alternative system of identification to DHEW which would have involved a two-part code requiring two separate parties to piece it together to identify a patient or physician. DHEW rejected Chalef's system, saying that former Secretary Caspar Weinberger had decided that the Social Security Identification system should eventually be implemented

The abstract (UHDA) has been proposed as the format on which the uniform hospital discharge data set (UHDDS) is to be collected for use by PSROs, and Medicare and Medicaid intermediaries. The UHDDS contains 14 data elements (such as patient I.D., date of birth, sex, race, admission date and hour, diagnoses, attending physician, and the like).

Besides criticizing the Social Security number, critics have charged that mandating the format design introduces a rigidity that will be difficult for hospitals to live with. It will mean, they say, that current abstracting systems will have to be thrown out and replaced by something totally new.

The government argues that the UHDA will make for more consistency and comparability of data, will reduce duplication of effort in recording data within the hospital and will provide a form that can later be used for all hospital discharges.■

## BQA prepares to decentralize some operations to regions

Sometime this summer, the PSRO program should be well enough under way, the Bureau of Quality Assurance reckons, to begin decentralizing some of the day-to-day operations.

After long controversy within BQA over how long to keep PSRO centrally administered,

preparations are being made to transfer to DHEW regional staff some of BQA's responsibility in overseeing the individual PSROs, said Daniel Nickelson, deputy director of the program operations.■

## PSRO groups learning collective voices get attention in government

Groups of PSROs in three regions of the country have discovered, not surprisingly, that their collective voices project far louder to the government than their separate voices.

Of the three groups, the California Association of PSROs (CAPSRO), begun about a year ago, has become the most formalized, with officers and status as a division of United Foundations for Medical Care, the state support center.

In the East there are the Northeast Conference of PSROs, consisting of PSROs in Region I (New England), which has met three times in more than a year, and the Mid-Atlantic Conference, made up of PSROs in Regions II and III (the swath of seven states from New York through Virginia), which has met twice since its formation last November.

### DHEW RECEPTIVE

The two East Coast conferences are loose, informal' organizations, with no constitutions or officers. Although the support centers in Massachusetts and Connecticut (for Region I) and in New York (for Region II) have handled most meeting arrangements, the member PSROs host the meetings in rotation, and no one PSRO administrator or officer dominates. Attendance or input does not obligate a PSRO to agreement or involvement with any specific action of the group. The conferences do, however, establish positions on issues of common concern and then present their endorsements to representives of DHEW, whom they have found receptive.

DHEW encourages the regional groups to meet, and it approves the use of PSRO funds to finance the events in the regions and expenses for travel to them. Participants say that Michael J. Goran, M.D., director of the Bureau of Quality Assurance, and Theodore Cooper, M.D., assistant secretary for health, welcome the dialogue that the conferences foster. They commend the two DHEW officials for their commitment to discussing problems with PSRO administrators, their flexibility in conceding mistakes and entertaining alternatives, and their willingness to carry messages from the regions back to Washington. Indeed, Raymond G. Richardson, M.D., president of CAPSRO, describes the change in relationship with BQA thus: "Until we banded together we couldn't make successful contact with Dr. Goran. Then we got him to come out and talk about our problems. From that point on our relationship has been beneficial rather than adversary."

### DUAL PURPOSE

Although the effectiveness of the conferences has not been established, participants agree that the meetings do serve an educational purpose for both DHEW and the PSROs in that on one hand, they remove some of the helplessness and alienation felt by many PSROs when dealing alone with the government, and, on the other, they convey directly and collectively the feelings of many individual PSROs.

Daniel Nickelson, deputy director of the division of program operations of the BQA, says the regional conferences can have a tremendous impact on government decision makers. He sees PSROs and DHEW as, by definition, opposing forces, but finds that regional conferences serve to make DHEW personnel more aware of local PSRO problems.

PSROs have complained all along that DHEW is too rigid in its requirements for management, thereby denying local PSROs what they view as their rightful autonomy. "A good number of these complaints are valid," Nickelson said. "We really did overstep ourselves sometimes. There is good dialogue going on at these conferences, though all problems aren't resolved yet. We can't allow things to come to an impasse."■

## 18 planning PSROs due for conversion April 30

Now that the money is available, the Bureau of Quality Assurance has decided to convert 18 planning PSROs to conditional status by the April 30. Following that conversion, as many as possible of the remaining planning PSROs will be converted, it is hoped, by July 1.

BQA has also determined that the current conditionals, several of which are approaching the 24-month "expiration" of their conditional status, will be extended with the same status, until they have gotten into review of long-term care, according to Daniel Nickelson, deputy director of program operations. This means, he said, that there will be no operational PSROs for perhaps another year.

In addition to these plans, BQA, under restriction from the Office of Management and Budget, will fund no new planning PSROs until fiscal '77, beginning Oct. 1.■

## Mid-Atlantic Conference airs complaints about PSRO program to DHEW aides

The Mid-Atlantic Conference of PSROs in Regions II and III, organized by the New York Support Center, and concerned over problems nagging the PSRO program, got a hearing from government officials when it met Feb. 13 in Alexandria, Va.

Besides the biggest complaint--use of the Social Security number to identify physicians and patients on the discharge abstract (see story, pg.3)-- the participants aired their concerns over norms, criteria and standards, the state support centers, and the method of federal PSRO budgeting.

The conference supported the concept of local determination of norms, criteria and standards for PSROs rather than regional determinations. Participants contended that norms and standards must vary with the geography and economics of a locale, citing the predicament of New Jersey and Puerto Rico, which, because they are in the same region, would have to share the same set of norms and standards if a regional basis is used.

### BACK SUPPORT CENTERS

The conference endorsed the continued direct federal funding of state support centers. Current government policy to drop this financing is now being reconsidered.

Operating on a program budget instead of the present line budget that PSRO contracts require is another change the conferees would like to see come out of the Bureau of Quality Assurance. PSRO administrators find this system of petitioning Washington for every expenditure not specifically spelled out to be unworkable. The conference asked for implementation of a program-budget procedure, under which they would receive a lump sum of money to operate and would not have to account for individual expenditures.

The PSROs also objected to what they consider excessive DHEW influence on the formulation of individual PSRO bylaws. ■

## Government's proposal for allotting slots on statewide councils contested

Now that statewide PSRO councils are about to formed, discussions in the six eligible states (Massachusetts, Connecticut, New York, Maryland, Pennsylvania and California) have revealed vigorous objection in Massachusetts to the government's proposal to give one seat each to an MD and a DO representative in the slots designated for the state medical society.

### OSTEOPATH ACTIVITY CITED

The Bureau of Quality Assurance has determined that there are three states where there is "significant osteopathic activity,"--Massachusetts, Pennsylvania and New York. Physicians in Massachusetts contend, however, that less than one-and-a-half percent of physicians in the state are osteopaths. BQA has agreed to take a second look at its proposed policy.

Meanwhile, by mid-March the solicitation will have begun for nominees to the statewide councils.

The prescribed representation is: one representative from each PSRO; four physicians (two selected by the state medical society, two by the state hospital association); and four public members (two of whom are chosen from a list of four submitted by the governor, and the remaining to be selected by the Secretary of DHEW).

BQA hopes to have the first meeting of the councils sometime this summer. ■

## AAPSRO workshop to explore latest data system information

A three-day workshop to explore the latest information about PSRO data systems is planned for March 19 through 21 in Salt Lake City, sponsored by the American Association of PSROs.

Roundtable discussions will deal with confidentiality, security of data, subcontracts, data elements and federal reporting requirements, among other topics.

Staff people from the Bureau of Quality Assurance and from most of the country's PSROs will attend, as well as representatives of data systems, who will be available to answer questions about their companies' capabilities, said Hugh McWilliams, executive director of AAPSRO.

The AAPSRO is a national organization with 109 institutional members and 210 individual members. With headquarters in Stockton, California, it is a spinoff of the American Association of Foundations for Medical Care with which it shares an office in Washington. That branch, as of the first of this month, has as its director William Fullerton, formerly with the House subcommittee on health of the Ways and Means Committee.

Annual dues for institutions has recently been raised to $500, the maximum figure the Bureau of Quality Assurance will allow PSROs to spend on membership. ■

## Criteria and quality assurance: the search for the best means of measuring medical outcome

After tracing the quest for a means to measure medicine, the author, C. Grant LaFarge, M.D., explores two types of criteria -- explicit and implicit -- from his perspective as chairman of the data-and-research committee of Bay State (Mass.) PSRO, the nation's largest PSRO. He suggests the explicit criteria might best be used for retrospective review while implicit criteria may be more rewarding for use in concurrent review.

With the rise in the cost of medical care has come a corresponding increase in the public's desire to know whether the care it receives is the best and most effective available and whether it is worth its enormous cost.

### WHAT YARDSTICK?

It has become clear, therefore, that medicine must be measured. The dilemma lies in deciding how to measure accurately and meaningfully an entity that is not only complex in structure and almost infinitely various in form, but one that is also in large degree an art as well as a science. The complexity, the variety, and the artistry are all sources of the difficulties that arise in attempting to select a suitable yardstick. To be useful, a yardstick must be objective, fair, and uniformly applicable, and must provide for significant comparability. Further, American standards of fair play demand that the measurement be an open process, subject to review by representatives of relevant constituencies.

The outcome of health care might seem to be the logical object of measurement, but real difficulty lies in arriving at agreement on what constitutes a good outcome. Is it improvement in health, restoration to a pre-illness state of health or to a "normal" state, or simply the arresting of a downhill course? Is a good outcome that which is viewed as such by the physician, the patient, the hospital, or some representative body in society? Should a good outcome be measured in absolute terms, as for example by the level of the patient's functioning in society, or in comparative terms, relating outcome to similar outcomes in related populations with the same problem treated by different methods, physicians, or institutional environments? Because society has not yet found a way to answer these complex and varied questions, the search for the ideal way to measure outcome has so far been fruitless.

### PROCESS MEASUREMENTS

Since the "processes" of medicine are more readily definable and more accessible to the yardstick than outcomes, they have become instead the target of the measurers. The measuring stick takes three forms: criteria, norms, and standards. Criteria, which are "predetermined elements against which aspects of the quality of a medical service may be compared," are a distillate of professional data, expertise, and judgment, arrived at by a form of specialty-society consensus. Norms are "numerical or statistical measures of usual observed performance," and, thus, constitute one of the data elements entering into criteria. Standards are "the range of acceptable variation from a norm or criterion," also a derivative of professional consensus.

The Professional Standards Review Organization, created by the 1972 Bennett amendment to the Social Security Act, has been charged specifically with the measurement of: the necessity of admission of a patient to a hospital (justification of admission and level of care); the necessity for remaining in hospital beyond certain standard lengths of stay determined by diagnosis; and, justification that "services ordered and rendered are consistent with the criteria specified."

### LEVEL OF CARE APPROACH

Exactly what criteria should be used? In the early days of utilization review under Medicare, "level of care" was the yardstick: the certifications of the attending physician and the reviewing physician, that the patient's problem warranted hospitalization and continued stay, were all that were required. This approach, manifestly, lacked objectivity. With health-care costs exceeding 8 percent of the annual Gross National Product, the question was asked: If specific criteria could be used for retrospective medical-audit studies, why could they not also be used for concurrent review of such issues as justification of admission, extension of stay and use of medical resources?

Under contract with the Bureau of Quality Assurance, the American Medical Association, with the direct participation and consultative review of 38 specialty societies, developed a model set of screening criteria by diagnosis. Items of justification or validation were given for admission to hospital, extension of hospital stay, diagnosis, critical diagnostic tests and services, discharge status, and compli-

cations. Strong emphasis was also given to what the criteria would not do: define how physicians must practice medicine; define rigid standards of quality; preclude innovations; and define what services would be paid for as part of claims review.

## EXPLICIT CRITERIA

From this apparently rational approach came "explicit" criteria that have several limitations. First, only five items can be specified for each element of the model, thus limiting the number of "acceptable" reasons for admission. Level-of-care criteria, admittedly loose, would have to be used in the event of an unlisted reason. Second, only single diagnoses were contained in the list, thus making no provision for the complexities of the large number of patients with multiple diagnoses. Third, in an era of defensiveness against claims of medical malpractice, the temptation to make certain that a patient conforms exactly to the specifications of the criteria has raised the question of inappropriate ordering of specified but unnecessary (in the physician's judgment) tests, or the failure to order others on "suspicion," for fear of nonconformity.

## 'IMPLICIT' SIGNS

Another approach in the search for the appropriate yardstick recognizes that a physician is trained to hospitalize a patient on the basis of a certain set of signs and symptoms of illness that require a hospital level of care, irrespective of the underlying diagnoses. These criteria, sometimes called "implicit," in fact define explicitly the logic of the underlying medical reasons for admission and extension of stay for: major and minor surgery; extensive diagnostic workup; acute and chronic illnesses; emergency, urgent, or elective admissions; and, extension of stay in hospital beyond the established checkpoints. These criteria have the advantage of including all possible situations, even those having to do with dental and psychiatric problems. They are coupled with standard length-of-stay tables to be used as checkpoints for review. They allow a coordinator, from any background, to perform the required review based on the information in the medical record of the patient, and to bring the case to the physician adviser's attention when appropriate. They have the disadvantage of appearing to be less "specific" and "objective," while having the advantage of being more universal.

Criteria to be used for the concurrent admission and extension of stay reviews will probably end by being a compromise between the "explicit" (disease-specific) and "implicit" (signs, symptoms and illness-specific). Evaluation in parallel will determine which has the greater objectivity and effectiveness in concurrent review, and which is the more economical in balancing the time spent by the coordinator (salaried) and by the physician adviser (piece work).

## ROLE IN MCE STUDIES

Disease-specific criteria have a real place, however, in medical care evaluation studies. A problem is identified by concurrent hospital review, and the solution may take one of two forms. If the problem is specific to the patient and the admission, it may be possible for the physician adviser, the patient's attending physician and the utilization-review committee to arrive at an answer by consensus. When the problem either is not resolved, or is generalized to the physician, the hospital or the system, a formal medical audit must be done. To achieve comparability in the results of such medical care evaluation studies among different hospitals, and among PSROs (even nationally), a basic common set of explicit criteria can be used. The local hospital can then add further criteria that are specific to its internal need for review of the question at hand.

At this point in our history, the prevailing interest is in getting on with the job of monitoring medical care for its quality, effectiveness and worth. It is well to remember that the application of any criteria--no matter how specific--is still an art in medicine. An "implicit" set of criteria would appear to be the most practical, effective and least costly in time and money for judging the necessity of hospital admission and extension of stay for patients with the signs and symptoms of illness. An "explicit" set of criteria would appear to be the most effective in making retrospective judgments about the way in which a particular physician or hospital handles the diagnosis or diagnoses which the patient proved to have.

## THE CHALLENGE

There are, as yet, no criteria for outcome that have achieved a professional and nonprofessional consensus and support, and it is the search for that desirable set of outcome criteria that is the challenge facing the measurers in the future. ■

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## FORUM
## The varied and complex effects of PSRO activities on hospital finances

The impact of PSRO activities on a hospital's finances ranges from the obvious, direct effects, such as review costs and payment denials, to complex effects buried in the always uncertain future of capital financing.

To take the simple effects first, the direct costs of review cannot help the hospital. At best, these costs will not be borne by the hospital, thus adding no new burden; at worst, the hospital will have to pay for review without getting reimbursed for it.

Payment-denial effects can also range from the harmless to the burdensome. At best (and most unreal), a hospital will never have certification denied for any patients. In the real world, however, certification denials ( no-pay decisions) will happen more or less frequently, and their effects will consequently vary from moderate annoyance to bankruptcy.

There are, in addition to these two types of financial impacts, some others that are less obvious. One that has received some discussion is the improvement in fiscal planning that a system of concurrent certification denials could provide better than a system of retrospective-payment denials. If a hospital administrator knows that payment will not be forthcoming for a patient, it may encourage the medical staff to provide the least expensive acceptable treatment for that patient, or even transfer him to another facility, thereby cutting its losses. If, however, the hospital and its physicians always provide the least costly possible medical care, concurrent review is no better in this regard than retrospective review, and the costs of processing concurrent review may be higher.

### EFFECT ON BORROWING

Yet another problem for the hospitals is the effect of PSRO review on a hospital's ability to borrow money to finance capital improvements, new construction and other long-term projects.

Private hospitals get long-term capital primarily from four sources: gifts (traditionally a major source, but lately less available), the federal government (Hill-Burton), bank loans and--in some jurisdictions--tax-exempt bonds.

One can hypothesize that gifts will continue to be given regardless of what the PSRO says about the hospital, provided that what it says isn't too damning. Although Hill-Burton loans were not tied by statute to PSRO approval, with the advent of HSA planning it is possible, if not probable, that the necessary planning approval will depend on the institution's meeting at least minimal PSRO-monitored standards.

### FINANCING BY BONDS & LOANS

That leaves bank loans and tax-exempt bonds. The mechanics of obtaining tax-exempt bonds typically take this form: The hospital "designs" the bonds and advertises their availability. Banking syndicates bid to "buy" the bonds, and the group that says it will assign the lowest interest rate wins the bidding. The bonds are then sold to the public by the winning bidder. The hospital pays off to the bank, which then pays the holders.

Both bank loans and tax-exempt bonds are dependent on the goodwill of the financial community. Basically, what this means is that bankers and bond underwriters want to be assured that the hospital is and will be financially sound until the loan is paid off or the bonds retrieved.

If the people who are underwriting the loan or bonds think that PSRO review will have a negative financial impact on the hospital, either immediately or in the long run, they can either refuse to take the risk or demand more stringent conditions from the hospital in other areas of its operations, such as the tightening up of bad-debt collections, in an attempt to reduce the likelihood of insolvency. The impact of such conditions on patient care may not be knowable at the time the loan or bond agreement is signed.

### THE BANKER'S VIEW

It is possible, of course, that a hospital whose PSRO profile is very good may find itself in a comparatively advantageous position in the bond market or at the bank. Until the financial community develops confidence in PSROs, however, it is more likely that the financiers will regard PSRO activities as a threat. If PSROs continue to concentrate on Medicare and Medicaid review and do not branch out into review of privately insured care, this could put those hospitals that take high percentages of elderly and welfare-dependent patients at a relative disadvantage in obtaining long-term capital. ■

Jean Rabinow, J.D.